WISCONSIN MEDICAL ASSISTANCE PROGRAM

HEALTHCHECK (EPSDT) SCREENING SERVICES HANDBOOK

PART D, DIVISION I

PART D, DIVISION I
HEALTHCHECK SCREENING SERVICES PROVIDER HANDBOOK
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part D, Division I, of the handbook will be numbered sequentially. This sequential numbering system will alert the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log will help eliminate errors and ensure an up-to-date handbook.

If you are missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 1D-3 and you receive 1D-5, you are missing 1D-4. If the provider is missing a transmittal, copies of complete provider handbooks may be obtained by completing the order form in Appendix 36 of the WMAP Part A Provider Handbook.

Transmittal Number	Initials	Issue Date
1D-1		03/92
1D-2		06/92
1D-3		11/92
1D-4		12/92
1D-5		10/94
1D-6		02/95
1D-7		05/95

Transmittal Number	Initials	Issue Date

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Chapters HSS 101-108 and by state and federal law. These regulations are interpreted for provider use in two WMAP provider handbooks. The two handbooks are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific handbook at the time of certification.

Additional copies of provider handbooks may be obtained by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental, etc.).

It is important that both the provider of service and the provider's billing personnel read this material prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales.

Providers should also be aware of other documents including state and federal laws and regulations, relating to the WMAP.

1. Chapter 49.43 - 49.497, Wisconsin Statutes

2. Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and the abbreviations appears in Appendix 30 of the Part A handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

HEALTHCHECK SCREENING SERVICES
TABLE OF CONTENTS

A. TYPE OF HANDBOOK

The HealthCheck Screening Services Handbook, Part D, Division I is the service specific portion of the Wisconsin Medical Assistance Provider Handbook. Part D, Division I includes information applicable to HealthCheck screening providers. The intent of this handbook is to provide information regarding provider eligibility criteria, covered services, reimbursement, and billing instructions for the HealthCheck program. The handbook should be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

How to Use This Handbook
This handbook is intended to:

1. Explain how the HealthCheck screening examination fits into the overall HealthCheck program.

2. Provide medical practitioners with all information needed to perform an effective, reimbursable WMAP HealthCheck screening examination.

3. Provide complete information on billing the WMAP.

Scope of Service
The policies in Part D, Division I govern all HealthCheck services provided within the scope of professional practice as defined in Chapter 49, Wis. Stats. and Wis. Adm. Code Chapter HSS 105. Covered services and related limitations are enumerated in Section II of this handbook.

Overview of the HealthCheck Program
HealthCheck is the WMAP's federally mandated program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (see Federal Regulation 42CFR, Part 441). HealthCheck consists of a comprehensive screening of WMAP recipients under the age of 21. The screening includes review of growth and development, identification of potential physical or developmental problems, preventive health education, and referral assistance to appropriate providers of service. HealthCheck also includes targeted outreach and case management services to "at-risk" children, to ensure that these children have access to needed medical, social and educational services. A detailed description of screening components is provided in Section II of this handbook. Information on HealthCheck outreach and case management services is contained in Part D, Division II.

The HealthCheck program involves three distinct activities:

1. Identifying recipients who are <u>not receiving</u> preventive care from <u>either</u> physicians or non-physician screeners.

2. Seeking recipients who are "at risk", educating them on matters of health, and helping them establish a relationship with a healthcare provider. HealthCheck outreach and case management are described in detail in Part D, Division II of the handbook, which is sent only to certified case management providers.

3. Providing HealthCheck screenings, assessments and referrals.

A. TYPE OF HANDBOOK (continued)

HealthCheck screening examinations may be distinguished from other preventive health care under the WMAP because:

1. HealthCheck includes a strong anticipatory guidance and health education component, a schedule for periodic examinations (based on recommendations by organizations that are recognized as authorities in the field of child and adolescent health), detailed documentation for necessary follow-up care, and increased provider involvement for ensuring that the recipient is appropriately referred for care.

2. HealthCheck screenings qualify Medical Assistance recipients under age 21 for certain benefits not otherwise covered by the WMAP (e.g., orthodontia treatment) and "Other Services". Refer to Section II-F of this handbook for additional information on "Other Services".

B. PROVIDER INFORMATION

Provider Eligibility and Certification

Wisconsin Administrative Code, Chapter HSS 105.37(1)(a) defines the following types of providers and agencies as eligible for HealthCheck screener certification:

1. Physicians;
2. Outpatient hospital facilities;
3. Health maintenance organizations;
4. Visiting nurse associations;
5. Local public health agencies;
6. Home health agencies;
7. Rural health clinics;
8. Indian health agencies;
9. Neighborhood health centers;
10. Nurse practitioners; and
11. Clinics operated under a physician's supervision.

Eligible providers who wish to become certified as a HealthCheck screener must submit their request in writing to:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

HealthCheck screening services must be performed by or under the supervision of skilled medical personnel within their scope of practice as allowed by state and federal law. Skilled medical personnel are:

1. Physicians (M.D. or D.O.)
2. Physician's Assistants
3. Nurse Practitioners
4. Public Health Nurses
5. Registered Nurses

Skilled medical personnel who perform physical assessment screening procedures must have successfully completed either a pediatric assessment or inservice training course on physical assessments that has been approved by the Department of Health and Social Services (DHSS). Paraprofessional staff may provide other individual components of a HealthCheck screening (excluding the physical assessment) if they are supervised by skilled medical personnel.

B. **PROVIDER INFORMATION** (continued)

Questions regarding HealthCheck clinical requirements may be directed to:

Bureau of Health Care Financing
Attn: HealthCheck Coordinator
Post Office Box 309
Madison, WI 53701-0309

Certification for Laboratory Services

All laboratories which test human specimens to determine health status are covered by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. CLIA governs every aspect of laboratory operation, including tests performed, personnel qualifications, quality control, quality assurance, proficiency testing, patient test management, and records and information systems. Every provider that performs laboratory tests must obtain a CLIA identification number and a certificate of waiver or a certificate of registration from the Health Care Financing Administration (HCFA). This applies to clinics and individual provider offices that perform laboratory tests.

Clinics with laboratories with more than one location must have a WMAP billing provider number for every laboratory which has a CLIA identification number in order to receive the correct reimbursement for laboratory services.

A laboratory may qualify for a certificate of waiver if it restricts its testing to the eight specific tests identified by HCFA as waived tests.. A laboratory performing other than waived tests is issued a certificate of registration.

If you refer specimens to an outside lab for testing, you may be reimbursed for a lab handling fee as described in Section IV of this handbook. However, the referral lab must be certified by the WMAP and must bill separately for the service in order for the service to be reimbursed.

Reimbursement for laboratory services is limited to procedures for which the performing laboratory has a valid CLIA certificate of registration or certificate of waiver in effect for the date of service.

Reimbursement

In recognition of the importance of comprehensive child health care, payment for HealthCheck screenings is at a higher rate than for other preventive exams such as "well baby" and "well child". Reimbursement for HealthCheck screening services is made in accordance with a maximum allowable fee schedule established by the DHSS. This payment schedule is based upon a variety of factors including usual and customary charges for similar types of services billed by non-screener physicians, costs generally incurred in obtaining immunization biologicals, and the Wisconsin State Legislature's budgetary constraints. In all cases, HealthCheck screeners will be reimbursed the lesser of the provider's usual and customary charge (the amount charged to non-Medical Assistance recipients for the same service) or the maximum allowable fee.

Maximum allowable fees exist for the comprehensive screening package for vision screens, hearing screens, and dental screens. Laboratory tests, immunizations, and pelvic exams should be billed additionally. In most situations, a comprehensive screen is performed. However, if a comprehensive screen is not appropriate, individual screens may be provided. (Detailed information on screening components and proper billing can be found in Sections II and IV of this handbook.)

B. PROVIDER INFORMATION (continued)

Reimbursement for vaccines provided through the Vaccines for Children Program (VFC) is limited to an administration fee, since the vaccines are provided free to providers who give immunizations. Refer to Section II-L and Appendix 1 of this handbook for information on the VFC, and to Sections II-C and IV-F for information on billing for vaccines.

Copies of the HealthCheck Maximum Allowable Fee Schedule may be purchased as indicated in Appendix 3 of the WMAP Part A Provider Handbook.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Section IV of the WMAP Part A Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

HealthCheck screening provider responsibilities include the following clinical and administrative activities.

1. Clinical activities include:

   a. performing all applicable screen components in a manner consistent with contemporary clinical practice.

   b. providing anticipatory guidance and health education, including nutrition evaluation and counseling, explanation of screening results and the importance of periodic HealthCheck exams, including the scheduling of next HealthCheck exam.

   c. documenting the screening tests performed and referrals made and billing the WMAP for these services in accordance with the guidelines presented in this handbook.

   d. giving the recipient a HealthCheck Verification Card or HealthCheck Referral Form as needed, for use as proof of screening so that the recipient can obtain certain services that are not usually covered by the WMAP (e.g., dental sealants).

   e. referring the recipient for an annual dental examination if a recipient over three years of age is not regularly receiving dental care.

   f. referring the recipient for any needed care that is not provided at the time of screening. If the recipient is in the Primary Provider Program, rules for the Primary Provider Program must be followed.

   g. reporting to the Center for Health Statistics, at the address listed below, any birth defect, adverse neonatal outcome, or developmental or other severe disability that is diagnosed or suspected as a result of a HealthCheck screening, pursuant to ch. HSS 116, Wis. Admin. Code.

      Center for Health Statistics
      Birth and Developmental
      Outcome Monitoring Program
      Post Office Box 309
      Madison, WI 53701-0309

B. PROVIDER INFORMATION (continued)

h. maintaining a confidential medical record of any service provided and all test results for each patient who receives a HealthCheck screening examination (HSS 105.37[1][c]b., Wis. Admin. Code). This record must include all information upon which claims for HealthCheck payment is based, including adequate documentation in the medical record that all the components of the screen have been completed).

2. Administrative activities include:

a. including, as applicable, the following written documentation in the recipient's medical record as stated in HSS 106.02 (9) (b), Wis. Admin. Code:

- Date, department or office of the provider, as applicable, and provider name and profession;
- Chief medical complaint or purpose of the service or services;
- Clinical findings;
- Diagnosis or medical impression;
- Studies ordered, such as laboratory or x-ray studies;
- Therapies or other treatments administered;
- Disposition, recommendations and instructions given to the recipient, including any prescriptions and plans of care or treatment provided; and
- Prescriptions, plans of care and any other treatment plans for the recipient received from any other provider.

b. preparing and maintaining truthful, accurate, complete, legible and concise documentation and medical and financial records according to HSS 106.02 (9) (a), Wis. Admin. Code, . In addition to the documentation and recordkeeping requirements specified in HSS 106.02 (9) (b), (c), and (d), Wis. Admin. Code, the provider's documentation, unless otherwise specifically contained in the recipient's medical record, must include:

- The full name of the recipient;
- The identity of the person who provided the service to the recipient;
- An accurate, complete and legible description of each service provided;
- The purpose of and need for the services;
- The quantity, level and supply of service provided;
- The date of service;
- The place where the service was provided; and
- The pertinent financial records.

c. Maintaining the following financial records in written or electronic form as stated in HSS 106.02 (9) (c), Wis. Admin. Code:

B. **PROVIDER INFORMATION** (continued)

- Payroll ledgers, cancelled checks, bank deposit slips and any other accounting records prepared by the provider;
- Billings to Medical Assistance, Medicare, health insurance, or the recipient for all services provided to the recipient;
- Evidence of the provider's usual and customary charges to recipients and to persons or payers who are not recipients;
- The provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;
- Billing claims forms for either manual or electronic billing for all health services provided to the recipient;
- Records showing all persons, corporations, partnerships and entities with an ownership or controlling interest in the provider, as defined in 42 CFR 455.101; and
- Employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous five years. Employee records must include employee name, salary, job qualifications, position description, job title, dates of employment and the employee's current home address or the last known address of any former employee.

d. Maintaining the following according to HSS 106.02 (9) (d), Wis. Admin. Code:

- The provider must maintain documentation of all information received or known by the provider of the recipient's eligibility for services under Medical Assistance, Medicare or any other health care plan, including but not limited to an indemnity health insurance plan, a health maintenance organization, a preferred provider organization, a health insuring organization, or health insurance;
- The provider must retain all evidence of claims for reimbursement, claim denials and adjustments, remittance advice, and settlement or demand billings resulting from claims submitted to Medical Assistance, Medicare, or health insurance; and
- The provider must retain all evidence of prior authorization requests, cost reports and supplemental cost or medical information submitted to Medical Assistance, Medicare and health insurance, including the data, information and other documentation necessary to support the truthfulness, accuracy and completeness of the requests, reports, and supplemental information.

e. Retaining all records of services rendered for a period of not less than five years from the date of payment (HSS 105.02[4], Wis. Admin. Code).

f. complying with all other provider responsibilities cited in HSS 101-108 of the Wisconsin Administrative Code and Section IV of the WMAP Part A Provider Handbook.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care coverage, or Medicare coverage.

Medical Assistance identification cards are sent to recipients on a monthly basis. All cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V-C of the WMAP Part A Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards and how to verify eligibility. Section V-C of Part A must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of the WMAP Part A Provider Handbook.

HealthCheck Program Recipient Eligibility

Any recipient under 21 years of age with a valid current Medical Assistance identification card is eligible for a HealthCheck screening, unless:

1. The recipient is enrolled in a WMAP-contracted managed care program (indicated by a yellow Medical Assistance card). Only the managed care program or its affiliated providers may provide the screening for that recipient.

2. The recipient has recently received a HealthCheck screening. The WMAP does not reimburse providers for comprehensive HealthCheck screenings more frequently than allowed under the HealthCheck Periodicity Schedule (Appendix 5 of this handbook), although interperiodic screens may also be billed. (See Sections II-A and II-D of this handbook.)

Copayment

No copayment may be charged for a HealthCheck screening provided to a recipient under 18 years of age, or to any recipient enrolled in a WMAP-contracted managed care program.

A $1.00 screening copayment must be collected from any recipient between 18 and 21 years of age for comprehensive screenings only. Applicable copayments will be automatically deducted by EDS from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of the recipient copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, and 22a of the WMAP Part A Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

C. **RECIPIENT INFORMATION** (continued)

Medical Assistance recipients enrolled in a WMAP-contracted managed care program are entitled to all of the same HealthCheck benefits outlined in this handbook, including a referral for dental and other medically necessary services (see Section II-F of this handbook for a description of HealthCheck "Other Services"). For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for HealthCheck services are established by the contract between the managed care programs and certified providers.